PHYSICIAN'S REPORT FOR ASSISTED LIVING HOME

FOR RESIDENT / CLIENT OF, OR APPLICANT FOR ADMISSION TO, HOME CARE FACILITIES

Our Facilities The Pines: (928) 526-1876 Pine Meadows Ranch: (928) 522-8622	**Main Office:** Phone: (928) 635-6750 Fax: (928) 635-6751 688 S. Garland Prairie Rd Williams, AZ 86046 Download this form at www.FlagstaffCareHomes.com

NOTES TO PHYSICIAN:

- -The person specified below is a resident / client of or an applicant to a licensed Assisted Living Home
- -These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents / clients.
- - THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
- - The information that you complete on this person is required to assist in determining whether he/she is appropriate for admission to or continued care in our facilities. We will also use this information to help us give them the best daily care within our power.

RESIDENT / CLIENT INFORMATION

Name	Date of Birth	Social Security Number
Street Address City State Zip		Telephone

AUTHORIZED FOR RELEASE OF MEDICAL INFORMATION (To be completed by person's authorized representative)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

Patient Name
To (Name and Address of Licensing Agency)
Signature of Resident/Potential Resident and/or His/Her Authorized Representatives

PATIENT'S DIAGNOSIS (To be completed by the Physician)

Primary Diagnosis
Secondary Diagnosis

Age	Sex	Height	Weight	In your opinion, does this person require skilled nursing care

Date of Last Tuberculosis Test	TB Results (Circle One) None Inactive Active	Treatment Needed (If Yes, see next line) Yes No

Explain Type of Treatment Needed
List Any Contagious Diseases
List Any Allergies
Patient Ambulates With (Circle One) Unassisted Cane Quad Cane Walker Wheelchair Other (explain):

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I. PHYSICAL HEALTH STATUS (Circle One) GOOD FAIR POOR

	Yes	No	Assistive Device
1. Auditory Impairment			
2. Visual Impairment			
3. Wears Dentures			
4. Special Diet			
5. Substance Abuse Problem			
6. Bowel Impairment or Incontinency			
7. Bladder Impairment or Incontinency			
8. Motor Impairment			
9. Requires Continuous Bed Care			

II. CAPACITY FOR SELF CARE (Circle One) GOOD FAIR POOR

	Yes	No	Comments
1. Able To Care For All Personal Needs			
2. Can Administer & Store Own Medications			
3. Needs Constant Medical Supervision			
4. Currently Taking Prescribed Medications			
5. Bathes Self			
6. Dresses Self			
7. Feeds Self			
8. Cares For His/Her Own Toilet Needs			
9. Able To Leave Facility Unassisted			
10. Able To Ambulate Without Assistance			
11. Can Handle Stairs Without Assistance			

III. MENTAL HEALTH STATUS (Circle One) GOOD FAIR POOR

	No Problem	Occasional	Frequent	Comments
1. Confused				
2. Able To Follow Instructions				
3. Depressed				
4. Able To Communicate				
5. Potential For Wandering				
6. Requires Observation While Sleeping (Night Bed Checks)				

Please List Over-The-Counter Medication That Can Be Given To The Client/Resident, As Needed For The Following Conditions:

1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Other (specify condition)	

Please List Current Prescribed Medications That Are Being Taken By Client / Resident:

1. ______________________________ 5. ______________________________ 9. ______________________________

2. ______________________________ 6. ______________________________ 10. ______________________________

3. ______________________________ 7. ______________________________ 11. ______________________________

4. ______________________________ 8. ______________________________ 12. ______________________________

Physician's Name ____ **Phone:** __________________

Address ____

Physician's Signature ____ **Date:** ______________

Pine Meadows Ranch Assisted Living Home

Physicians Routine Orders

Constipation:		
Milk of Magnesia	**30 ml by mouth**	**Every day if no BM**
GI Upset:		
Mylanta	**30 ml by mouth**	**3x daily as needed**
Diarrhea:		
Kaopectate	**30 ml by mouth**	**3x daily as needed**
Pain:		
Tylenol	**650 mg. by mouth**	**If no allergy to Tylenol every 6 hours as needed**
Fever:		
Tylenol	**650 mg. by mouth**	**If no allergy to Tylenol every 6 hours as needed for temp over 100 degrees.**

Resident Name:____

Allergies:____

____

____

____

Physician Printed Name: ____

Physician Signature: ___________________________ Date: ___________

The Pines: 7885 Easy St
Flagstaff, AZ 86004
Phone 928-522-8622

Download this form on our website: www.FlagstaffCareHomes.com

Pine Meadows Ranch Assisted Living Home

Physician's Consent for Administration of Medication

To Whom It May Concern:

I authorize the certified caregivers from Pine Meadows Ranch Assisted Living Home to assist with self-administration and/or administration for (patient name) _________________________________ on a daily basis.

I also authorize the certified caregiver and/or manager to place the medications in a mediset on a weekly basis as needed.

Physician's Printed Name: _______________________________________

Physician's Signature: ____________________________ Date: ________

Pine Meadows Ranch Assisted Living Home
7885 Easy St
Flagstaff, AZ 86004
Phone: 928-522-8622

Pine Meadows Ranch

Current Tuberculosis Test Results

Patient Name: ____

Testing Location: ____

Date of Test: _________________ Date Read: ___________________

Test Results: ☐ Negative ☐ Positive

I verify that the test results for the above named patient are true:

Printed Name of Medical Practitioner ______________________________

Signature: ____________________________________ Date: __________